Special Article

Pediatrician Participation in Medicaid—Findings of a Five-Year-Follow-up Study in California and Elsewhere

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Medi-Cal—California's Medicaid program—underwent significant changes during the period 1978 through 1983. Most notable were the imposition of new copayments, reductions in physician reimbursement and selective contracting for hospital services. The state-funded medically indigent program was transferred to the counties and the state began to experiment with bulk purchasing of drugs and supplies, a lock-in for overutilizers and primary care case management.

How have these changes affected primary care providers' participation in Medi-Cal? Surveys of California pediatricians in 1978 and 1983 suggest that while most continue to participate, the level of limited participation in Medi-Cal increased from 23% to 51%. Most pediatricians express discontent with the level of Medicaid payments and there is a growing sentiment that Medicaid regulations interfere with the provision of high quality medical care. Future Medi-Cal policy developments, such as contracting for physician services, should be structured in ways that maximize participation of primary care providers in the program.

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During the early 1980s the federal government and many state governments began to reconsider their capacity and willingness to finance health care for the poor. The major impetus for this development was growing health care costs. Other related developments included fiscal pressures during a period of economic slowdown, widespread concern about taxes and public spending, the thrust of the "New Federalism" toward increasing the state role in public policy, concern with both long-term reform and short-term budget reduction in health care cost containment and a new willingness to subject health care to the forces of price competition.[1,2]

Nowhere were these developments more evident than in California. California's state revenues are usually well above expenditures and per capita spending exceeds the national average. But state Proposition 13 in 1978 and the more recent federal Medicaid budget reductions put significant pressure on the state budget. California's Medicaid program (Medi-Cal) is the country's largest: 3,747,880 people received Medi-Cal in 1982, making up 18% of total US recipients. Medi-Cal expenditures grew from $2.4 billion in 1978 to $3.6 billion in 1983. With rising program costs and state budget pressures, the emphasis of Medi-Cal policy changes between 1978 and 1983 was cost containment. This period saw particular reliance on utilization controls and heightened price competition among California's many health care providers to control Medicaid's costs.

Nationally, spiraling health care costs led to the Medicaid provisions included in the Omnibus Budget Reconciliation Act of 1981 (OBRA) and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). This federal legislation increased the fiscal pressure on state budgets by reducing the federal matching payments to the states for their Medicaid expenditures—by 3% in 1982, 4% in 1983 and 4.5% in 1984. In addition, it required Medicaid program reductions in eligibility and covered services, and gave states new policy options for Medicaid cost containment.

Efforts are currently under way to evaluate the impact of OBRA, TEFRA and other Reagan era health policy changes on health care costs. There is also concern, however, that these changes in Medicaid and the health care environment

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ABBREVIATIONS USED IN TEXT

IPA = independent practice association
OBRA = Omnibus Budget Reconciliation Act of 1981
PPO = preferred provider organization
TEFRA = Tax Equity and Fiscal Responsibility Act of 1982

may have eroded earlier gains in the access of the poor to health care.[3] Physician participation in Medicaid is a critical determinant of access to health care for the poor: when office-based physicians do not participate, patients must either rely on hospital emergency rooms, outpatient clinics or freestanding emergency rooms, where care may be relatively more expensive, or perhaps forgo care altogether.[4] Previous research has shown that Medicaid program characteristics affect physician willingness to accept Medicaid patients[5-7]; thus it is reasonable to hypothesize that recent policy developments have influenced Medicaid participation in California.

This paper examines the influence of recent Medi-Cal policy developments on the participation of California's pediatricians in the program. First, we describe changes in Medi-Cal policies between 1978 and 1983 in the areas of eligibility, covered services, reimbursement and cost containment. Second, we present data from 1978 and 1983 surveys of pediatricians concerning their Medicaid participation, comparing the responses of California pediatricians with those of pediatricians in other states. Finally, we analyze recent trends in pediatricians' Medi-Cal participation in the context of changes in the states' socioeconomic and health care policy environment, concluding with recommendations for fostering greater Medi-Cal participation among California pediatricians.

Research Methods

Information about physicians and their experiences with state Medicaid programs was collected in surveys conducted by the American Academy of Pediatrics in 1978 and 1983.[5] Since Medicaid policies vary widely by state and are expected to differ in their impact on physicians, states with differing Medicaid policy characteristics were chosen for a 1978 study of the impact of Medicaid policy on physician participation in the program. The 50 Medicaid programs were placed in four categories based on their 1975 scores on an index of Medicaid reimbursement levels and an index of other state Medicaid program attributes such as restrictiveness of eligibility and service provisions.[5] Thirteen study states were chosen randomly from the four categories. It was particularly important that several large states be included in the study because just a few large states account for most of the nation's Medicaid eligibles and expenditures. Thus, the probability of a state's selection was weighted by the number of pediatricians in the state. The study states chosen by this method are shown in Table 1. The same 13 states were included in a 1983 follow-up study.

A random sample of nonfederal, office-based physicians, distributed approximately equally across the 13 states, was selected from self-designated pediatricians included in the American Medical Association's masterfile (see Table 1). In the 1978 study, personal interviews were conducted with 814 physicians for an overall survey response rate of 92.6%. The 1978 response rate for California pediatricians was 93.5%.

Pediatricians surveyed in 1983 included the panel of 814 respondents from the 1978 study. While there was some attrition due to factors such as retirement and death, all but four of the panel physicians were located. A supplementary sample of pediatricians entering practice since 1978 was added to ensure that the age distribution of physicians surveyed in 1983 was representative of the pediatrician population. Survey data for 1983 were weighted to reflect the age distribution of office-based pediatricians in each state. A total of 791 pediatricians completed the 1983 questionnaire for an overall response rate of 79.7%. Overall response rates for the panel and the supplementary sample of new physicians were 83.7% and 71.9%, respectively; for California pediatricians response rates were somewhat lower at 71.1% and 60.0%, respectively. The state sample sizes for 1983 are shown in Table 1. Demographic characteristics of the pediatricians surveyed in 1978 and 1983 are shown in Table 2.

The pediatrician surveys included questions about the physician's practice characteristics and experiences with Medicaid as well as with the new alternative practice arrangements—for example, independent practice associations (IPAs) and preferred provider organizations (PPOs)—that have become more prevalent in recent years. Physicians were asked specifically if they accepted all, some or none of the Medicaid and non-Medicaid patients that contact them, and what proportion of their patient load was Medicaid. The measures of Medicaid participation are constructed from these items. Physicians were also asked to provide some information about fees and reimbursements, and to rate the importance of some commonly identified problems with the Medicaid program.

TABLE 1.—*State and Pediatrician Samples, 1978 and 1983*

State	State Sample Size 1978	1983
California	58	56
Colorado	53	55
Georgia	97	91
Indiana	77	71
Iowa	37	37
Maryland	64	64
Massachusetts	63	70
Nebraska	27	28
New York	54	53
Oklahoma	58	57
Pennsylvania	63	54
Tennessee	84	81
Texas	79	74
Total	814	791

TABLE 2.—*Description of the Sample*

Physicians Surveyed	California 1978	California 1983	Total All 13 States 1978	Total All 13 States 1983
Physicians surveyed, number	57	56	814	791
Sex, percent				
Male	91.4	91.1	89.8	88.1
Female	8.6	8.9	10.2	11.9
Board certified, percent	77.6	77.9	72.7	79.5
Foreign medical school graduates, percent	13.8	14.6	12.8	11.6

Data describing state Medicaid policies and economic, political and social conditions were gathered from secondary sources and verified by state Medicaid personnel. Changes in state Medicaid eligibility and covered services between 1978 and 1983 were identified using various publications which describe state Medicaid programs.[8-10] The analyses that follow also incorporate state socioeconomic information from the Census Bureau, the Bureau of Labor Statistics and the Department of Health and Human Services Office of Family Assistance.[11,12]

Highlights of Medi-Cal Policy Developments, 1978-1983

Overview

Our review of Medi-Cal policies during the period between 1978 and 1983 indicates many substantial program changes. Overall, the state did not initiate drastic eligibility reductions. Rather, various forms of utilization controls were initiated. In addition, several very fundamental changes were made in the state's strategy for reimbursing Medicaid providers. These changes are described below.

Medi-Cal Eligibility

As noted earlier, California's Medicaid program is the nation's largest, making up 18% of all US recipients. The program is broad in its eligibility provisions, covering much of California's poverty population. An estimated 39% of poor children were not covered by Medicaid in 1980, which compares favorably with the national average of 52%.[13]

OBRA mandatory provisions restricting eligibility were implemented gradually in late 1981 and early 1982; approximately 50,000 children lost eligibility because of these cuts.[12] Few other eligibility reductions were undertaken at the state's initiative, however. Notable exceptions were the transfer of responsibility for medically indigent adults to the counties and reduction of the medically needy program, which provides Medicaid benefits to families not qualifying for welfare. "Medically needy" families become eligible for Medicaid by "spending down" to a certain level by deducting medical expenses from their incomes. In California in 1983 this protected income level was $601 per month for a family of four; it had been reduced from $801 per month the previous year.

Medi-Cal Services

In addition to the eight federally mandated services, California provides 27 optional services. Several have been added since 1978. Also during this period the state began to experiment with primary care case management systems and home and community-based services on a demonstration basis. Economic efficiencies were sought through bulk purchasing of certain drugs and medical equipment.

In 1982 the state began limiting use of certain optional services to two occasions of service per month. Several other important steps were taken to control use of Medicaid services. These included a "lock-in" program restricting overutilizers to one pharmacy or one physician. In addition, the state began to require copayments for certain services and categories of recipients. For example, a $5 copayment was imposed on nonemergency care received in emergency rooms for all recipients except children younger than 12 years and women receiving prenatal care.

Medi-Cal Reimbursement

The most notable changes in Medi-Cal policies between 1978 and 1983 affected the reimbursement of providers.

TABLE 3.—*Overview of Participation*

Participating Pediatricians	*California* 1978 Percent	*California* 1983 Percent	*Total All 13 States* 1978 Percent	*Total All 13 States* 1983 Percent
Pediatricians who have ever participated in Medicaid	98.3	97.3	94.2	93.0*
Pediatricians who currently participate in Medicaid	98.2	91.4	85.1	82.0†
Average patient load covered by Medicaid (participants only)	32.5	24.3	15.7	14.7
Participants who limit participation in Medicaid	22.5	51.3‡	26.0	35.0‡

*$P < .10$.
†$P < .05$.
‡$P < .01$.

TABLE 4.—*Pediatrician Attitudes About Problems With the Medicaid Program*

Problems With the Medicaid Program as Evaluated by Respondents— % Rating Each of the Following as "Very Important":	*California* 1978	*California* 1983	*Total All 13 States* 1978	*Total All 13 States* 1983
Not all health care services are covered by Medicaid	28.6	31.7	26.1	31.0*
It takes too long to complete the necessary paperwork	43.1	36.0	33.7	35.8
It takes too long to receive payment from Medicaid	48.3	35.4	24.1	34.8
Medicaid program regulations are too complex	43.1	45.6	38.6	46.3†
Medicaid payments are too low	66.1	78.8	59.7	66.5†
Medicaid payments are too unpredictable	50.0	60.4	41.3	52.4†
Medicaid program regulations interfere with providing high quality medical care	25.9	43.5	29.4	32.8
Problems such as broken appointments and language barriers make it difficult to treat Medicaid patients	46.6	44.4	29.0	31.1
The type of patient who is eligible for Medicaid	...	19.4	...	14.8
There are few Medicaid eligibles in this area	...	2.7	...	5.0

*$P < .05$.
†$P < .01$.

First, in 1982, there was a 10% reduction in the level of physician reimbursement under the state's fee schedule, the California Relative Value Scale. Second, the basis of hospital reimbursement underwent several changes between 1978 and 1982 and, finally, in 1982 Medi-Cal began reimbursing hospitals based on selective contracting.[14,15] In areas where selective contracting was implemented, only those hospitals entering into an agreement with Medi-Cal were eligible to receive reimbursement. Payment to contracting hospitals is based on an all-inclusive negotiated daily rate.

Pediatrician Medi-Cal Participation: Survey Results

Pediatrician participation in Medi-Cal declined somewhat between 1978 and 1983 (see Table 3). The proportion of pediatricians reporting Medicaid participation fell from 98% to 91% between 1978 and 1983, a change that is very close to statistical significance. Despite the decline, however, the 1983 participation level is higher than the level for all 13 states.

Like other measures of Medicaid participation, the average percentage of patient load covered by Medicaid decreased, from 33% in 1978 to 24% in 1983, although this change was not statistically significant. Of California's original 1978 panel of physicians, 85% reported fewer Medicaid patients in their practices in 1983. California ranked first among the 13 states in the average Medicaid patient load in both 1978 and 1983.

While most California pediatricians continue to participate in Medicaid, a dramatic increase occurred in the proportion of California pediatricians choosing to limit Medicaid participation (see Table 3). These "limited participants" have room in their practices for additional patients but still choose not to accept all Medicaid patients who contact them. The level of limited participation increased from 23% in 1978 to 51% in 1983. California ranked third among the 13 states in the percentage of limited participation, surpassed only by Georgia and Pennsylvania.

Table 4 shows pediatricians' responses to questions about problems they experience with Medi-Cal. In both 1978 and 1983 the majority of pediatricians reported dissatisfaction with Medi-Cal payment levels, a problem shared with pediatricians surveyed in the other 12 states. Paperwork and bureaucratic complexity are also judged to be substantial problems by most California pediatricians in both 1978 and 1983. By comparison, these problems increased significantly in importance between 1978 and 1983 for the combined sample of pediatricians in all 13 states. The most significant change in attitudes among California's pediatricians is the growing sentiment that Medi-Cal regulations interfere with the provision of high quality medical care. Only 26% of California's participants identified this interference as very important in 1978 while 44% identified it as such in 1983.

One apparent explanation for decreased Medi-Cal participation in California is the widening discrepancy between physician fees and the program's reimbursement. Some of this discrepancy is undoubtedly due to the 10% reimbursement reduction implemented in California in 1982. Table 5 indicates the 1978 and 1983 self-reported physician fees and reimbursement levels for a well-child visit and for a medical follow-up visit. In 1978 the average Medicaid reimbursement for a well-child office visit covered 74% of a pediatrician's usual fee. The ratio dropped significantly by 1983 to 64%. The discrepancy is even wider for follow-up medical visits, for which physicians received 75% of their usual fee in 1978 and only 56% in 1983. Comparison with other states in the study supports the interpretation that Medicaid reimbursement affects participation: in general, states that have maintained high levels of participation (such as Iowa and Colorado), or have raised their participation levels (such as Tennessee), are those that have high or improving reimbursement relative to usual fees. Multivariate analyses of the total sample support this interpretation as well.[5,16]

Another reason for declining participation in Medi-Cal may be the bureaucratic complexity faced by pediatricians seeking reimbursement for services rendered to Medi-Cal patients. Our survey asked pediatricians to provide estimates for several indicators of the program's administrative perfor-

TABLE 5.—*Pediatrician Fees and Medicaid Reimbursement*

Pediatric Office Visits	California 1978	California 1983	Total All 13 States 1978	Total All 13 States 1983
Well-child office visit				
Average current usual fee	$21.90	$30.20	$16.63	$22.72
Average Medicaid reimbursement	16.30	19.20	11.81	15.85
Follow-up medical visit				
Average current usual fee	16.90	23.30	13.05	17.69
Average Medicaid reimbursement	12.60	13.00	9.83	12.65

TABLE 6.—*Medi-Cal Administration*

Medicaid Paperwork	California 1978	California 1983	Total All 13 States 1978	Total All 13 States 1983
Average % of Medicaid claims returned for additional work	11.0	19.0†	12.9	15.0*
Average number of weeks for Medicaid to make payment	8.1	8.0	7.2	6.5†
Average number of minutes to fill out a Medicaid form	7.5	8.7	7.3	6.9

*$P < .10$.
†$P < .05$.

mance such as the proportion of claims returned to the physicians' office for additional work after initial submission for reimbursement, the length of time between billing and payment and the time needed to complete a Medicaid claim. Table 6 indicates that in 1983 pediatricians report significantly more returned claims than in 1978. Other indicators of the program's administrative performance have remained unchanged.

In summary, pediatricians are troubled by Medi-Cal's declining reimbursement levels and increasing bureaucratic complexity. In addition, they are increasingly concerned that Medi-Cal regulations interfere with the provision of high quality medical care. Most pediatricians continued to participate in Medi-Cal between 1978 and 1983, with participants on average reporting Medi-Cal patients to be almost one quarter of their patient load. Significantly more California pediatricians, however, are finding it necessary to limit their Medicaid participation, perhaps in response to declining reimbursement, increased administrative overhead and dissatisfaction with other program regulations.

Discussion

Extraordinary changes have taken place in the delivery of health care in California during the last seven years, foreshadowing developments likely to occur in other states in the coming years. For this reason, it is important that the consequences of these changes be analyzed fully. Some of these changes involve Medi-Cal providers and patients only indirectly. These include the growing number of health care providers in California, the new incentives to reduce lengths of stay in hospital created by the Medicare prospective payment system and the evolution of alternative nonhospital delivery systems such as IPAs and PPOs that are negotiating discounted rates to provide care to the patients of California's private insurance carriers.

Other changes have affected Medi-Cal providers and patients more directly. Most notable is the implementation of selective contracting, which has redistributed Medi-Cal dollars and patients among California's hospitals on the basis of price competition. In comparison with this fundamental restructuring of Medi-Cal reimbursement, Medi-Cal eligibility and services changed only slightly between 1978 and 1983. Despite recent budget pressures, California's children have generally continued to enjoy the benefits of a Medicaid program that extends broad eligibility and services. The important question in California is not so much whether a poor child will be eligible to receive needed services in that 61% of California's low-income children are covered by the program. Rather, the important question is where that care is likely to be available.

Pediatrician unwillingness to participate in Medi-Cal increased between 1978 and 1983, with dramatic increases in those limiting their participation. Recent reductions in Medi-Cal reimbursement levels probably account in part for the increasing dissatisfaction with the program. Indeed, in 1983 nearly 79% of California pediatricians reported that low Medi-Cal payments were a very important problem—up from 66% in 1978 and well above the total for pediatricians in all 13 states.

Private insurer contracting for the provision of nonhospital care may also be discouraging physicians from continuing to participate in Medi-Cal. Faced with increased competition, pediatricians are joining the ranks of the new IPAs and PPOs in order to enhance their advantage in the privately insured market.[14] In the scramble for market share, primary care providers appear to be limiting their commitment to publicly financed patients.

The prospect of state contracting for nonhospital Medi-Cal services may also be discouraging pediatrician participation in the program, especially since many California pediatricians are participating in the very IPAs and PPOs most likely to bid for Medi-Cal contracts in the future. However, California's primary care physicians have sustained Medi-Cal fee schedule reductions in recent years and may not accept further reductions in reimbursement. Competitive pressures may not be sufficient to force certain IPAs and PPOs into the Medi-Cal bidding, and the result would be a dramatically altered distribution of California's poor children among Medi-Cal providers in the future. In the process, the current access of Medi-Cal children to health care could be seriously compromised. Moreover, to the extent that these children must obtain primary care in hospital-based settings, the costs may be unnecessarily high.

Primary care physicians (whose office-based services are generally less expensive than those of outpatient departments and emergency rooms) might be attracted into state-initiated contractual arrangements both in California and elsewhere. If children are to have access to primary care in physicians' offices, however, state Medicaid programs will need to foster Medicaid participation. Our research suggests that states will need to preserve adequate reimbursement levels—whether capitation-based or fee-for-service. In addition, efforts need to be made to minimize paperwork associated with billing state Medicaid programs and to address the perception of physicians that Medicaid regulations interfere with the provision of high quality medical care to low-income patients.

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